Care Quality Commission

Inspection Evidence Table

Dr Abdul-Kader Vania (1-493977210)

Inspection date: 27 January 2020

Date of data download: 13 January 2020

Overall rating: Requires Improvement

The practice is rated as requires improvement overall and in the safe and well-led key questions. This is because they were unable to demonstrate that systems in place to manage and mitigate risk were always effective. The practice was further unable to demonstrate that they had oversight of these systems to ensure that they were working as intended. The practice was rated as inadequate for providing an effective service because cervical screening and childhood immunisation uptake were not in line with national targets and no action could be provided that showed taken to address this.

Please note: Any Quality Outcomes Framework (QOF) data relates to 2018/19.

Safe Rating: Requires Improvement

The practice was rated requires improvement for providing safe services because they were not always able to demonstrate that systems in place to consider or mitigate risks were effective, or that there was an overall system of oversight to ensure systems were updated or working as intended.

Safety systems and processes

The practice did not always have clear systems, practices and processes to keep people safe and safeguarded from abuse.

Safeguarding	Y/N/Partial
There was a lead member of staff for safeguarding processes and procedures.	Y
Safeguarding systems, processes and practices were developed, implemented and communicated to staff.	Y
There were policies covering adult and child safeguarding which were accessible to all staff.	Y
Policies took account of patients accessing any online services.	Y
Policies and procedures were monitored, reviewed and updated.	Y
Partners and staff were trained to appropriate levels for their role.	Partial[1]
There was active and appropriate engagement in local safeguarding processes.	Y
The Out of Hours service was informed of relevant safeguarding information.	Y
There were systems to identify vulnerable patients on record.	Y
Disclosure and Barring Service (DBS) checks were undertaken where required.	Partial[2]
Staff who acted as chaperones were trained for their role.	Partial[3]

Safeguarding	Y/N/Partial
There were regular discussions between the practice and other health and social care professionals such as health visitors, school nurses, community midwives and social workers to support and protect adults and children at risk of significant harm.	Y

Explanation of any answers and additional evidence:

1. The practice had a new practice manager who had been in post for approximately eight weeks. Although policies had in most cases been updated and reviewed, all training had gone out of date but only by two days.
2. Although the practice could demonstrate that DBS checks had been completed for the staff, whose files we viewed, one of these was completed in 2012. The practice could not demonstrate that they had considered the risk of not completing ongoing checks to assure themselves that staff remained suitable for their role in this regard. Practice leadership told us that they would address this immediately.
3. Practice staff we spoke with, who acted as chaperones, were aware of their role and could articulate what actions they would take when asked to perform the duty, but we found that all of their training was out of date, however this was only by two days. Following the inspection, the practice provided us with two additional certificates for chaperoning, only one of these was in date. The system in place was not yet fully effective.

   Practice leadership told us that all systems had been entrusted to one member of staff prior to our visit, who had left unexpectedly. There was no system of oversight to ensure that these had been completed or could be completed promptly as current practice management were unable to access the training system. The practice leadership team told us that they had emailed NHS IT support in order to gain access to the training software but had not yet achieved this.

Recruitment systems	Y/N/Partial
Recruitment checks were carried out in accordance with regulations (including for agency staff and locums).	Y
Staff vaccination was maintained in line with current Public Health England (PHE) guidance if relevant to role.	Y
There were systems to ensure the registration of clinical staff (including nurses and pharmacists) was checked and regularly monitored.	Y
Explanation of any answers and additional evidence:	

Safety systems and records	Y/N/Partial
There was a record of portable appliance testing or visual inspection by a competent person. Date of last inspection/test: January 2020	Y
There was a record of equipment calibration. Date of last calibration: February 2019	Y
There were risk assessments for any storage of hazardous substances for example, liquid nitrogen, storage of chemicals.	N[1]

There was a fire procedure.	Y
There was a record of fire extinguisher checks. Date of last check: April 2019	Y
There was a log of fire drills. Date of last drill: January 2020	Partial[2]
There was a record of fire alarm checks. Date of last check: January 2020	Y
There was a record of fire training for staff. Date of last training: January 2019	Y
There were fire marshals.	Y
A fire risk assessment had been completed. Date of completion: March 2019	Y
Actions from fire risk assessment were identified and completed.	No[3]

Explanation of any answers and additional evidence:

1. Although data sheets were available for the products used throughout the practice, they were unable to demonstrate that they had completed COSHH risk assessments. We found that a COSHH item had been left in an area where patients could access. Staff we spoke with were able to articulate where the Personal Protective Equipment (PPE) was kept and how to use it appropriately.
2. The practice was able to demonstrate that a fire drill had been completed in January 2020 but were unable to demonstrate that there had been an effective system in place before this to ensure fire drills were completed regularly.
3. The practice was unable to demonstrate that actions identified through their fire risk assessment had been completed or that there was an adequate system in place to ensure that these had been addressed.

Health and safety	**Y/N/Partial**
Premises/security risk assessment had been carried out. Date of last assessment: June 2016	Partial[1]
Health and safety risk assessments had been carried out and appropriate actions taken. Date of last assessment: June 2014	Partial[2]

Explanation of any answers and additional evidence:

1. The practice was able to provide a premises risk assessment from 2016 but was unable to demonstrate that this had been repeated or that there was a system in place for oversight to ensure that these risks were considered, or actions completed.
2. The practice was able to provide a Health and Safety (H&S) risk assessment from 2014 but was unable to demonstrate that this had been repeated or that there was a system in place for oversight to ensure that these risks were considered, or actions completed. We found that blind loops in a consultation room were present and no ligature risks had been considered or actions completed. Following the inspection, the practice provided evidence that this had been addressed.

Infection prevention and control

Appropriate standards of cleanliness and hygiene were met but the system to ensure this was ineffective.

	Y/N/Partial
There was an infection risk assessment and policy.	Y
Staff had received effective training on infection prevention and control.	Partial[1]
Infection prevention and control audits were carried out. Date of last infection prevention and control audit: January 2019	Y
The practice had acted on any issues identified in infection prevention and control audits.	Y
There was a system to notify Public Health England of suspected notifiable diseases.	Y
The arrangements for managing waste and clinical specimens kept people safe.	Y

Explanation of any answers and additional evidence:

1. The practice lead for infection control, the practice nurse, had left the practice and there was no new lead identified. None of the staff, whose files we viewed had been trained in clinical infection control procedures. We were told by the practice leadership, that this role would have to be completed by a clinician, but there was no system in place to ensure this, or to ensure that infection control procedures would be completed in the absence of one individual. Following the inspection, the practice told us that they had recruited a new nurse and had designated this role to her.

Risks to patients

There were some systems to assess, monitor and manage risks to patient safety.

	Y/N/Partial
There was an effective approach to managing staff absences and busy periods.	Y
There was an effective induction system for temporary staff tailored to their role.	Y[1]
Comprehensive risk assessments were carried out for patients.	Y
Risk management plans for patients were developed in line with national guidance.	Y
The practice was equipped to deal with medical emergencies (including suspected sepsis) and staff were suitably trained in emergency procedures.	Y
Clinicians knew how to identify and manage patients with severe infections including sepsis.	Y
Receptionists were aware of actions to take if they encountered a deteriorating or acutely unwell patient and had been given guidance on identifying such patients.	Y
There was a process in the practice for urgent clinical review of such patients.	Y
When there were changes to services or staff the practice assessed and monitored the impact on safety.	Y

Explanation of any answers and additional evidence:

1. The practice demonstrated that the induction procedure was comprehensive, although no new staff had been recruited recently. The induction procedure did not indicate that staff had been informed of

local safeguarding procedures, although we saw posters on the walls of consultation rooms and long-standing staff we spoke with were able to tell us where they would find this information.

Information to deliver safe care and treatment

Staff did not always have the information they needed to deliver safe care and treatment.

	Y/N/Partial
Individual care records, including clinical data, were written and managed securely and in line with current guidance and relevant legislation.	Y
There was a system for processing information relating to new patients including the summarising of new patient notes.	Y
There were systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment.	N[1]
Referral letters contained specific information to allow appropriate and timely referrals.	Y
Referrals to specialist services were documented and there was a system to monitor delays in referrals.	Y
There was a documented approach to the management of test results and this was managed in a timely manner.	Y
There was appropriate clinical oversight of test results, including when reviewed by non-clinical staff.	Y
The practice demonstrated that when patients use multiple services, all the information needed for their ongoing care was shared appropriately and in line with relevant protocols.	Partial[2]

Explanation of any answers and additional evidence:

1. The practice was unable to demonstrate that formal clinical meetings had taken place to consider complex patients, or risks to patients. There was no system in place that could be adequately demonstrated to share information between clinicians effectively to ensure risks to patients were considered or addressed. The practice leadership told us that health visitors and other professionals had been invited to meetings but were unable to demonstrate that information had been shared with them as meetings had not been documented. The practice leadership told us that they had informal daily huddles and we saw that formal practice meetings had been held regularly from December 2019, from when new practice management had joined the practice. The practice was unable to demonstrate practice meetings to share learning had taken place before this. The practice also told us that they did not share good practice or learning with any other practice and had not considered the risk of a closed culture.
2. The practice leadership told us that information is only shared with Out of Hours (OOH) providers when necessary.

Appropriate and safe use of medicines

The practice had systems for the appropriate and safe use of medicines, including medicines optimisation but these were not always fully effective.

Indicator	Practice	CCG average	England average	England comparison
Number of antibacterial prescription items prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/10/2018 to 30/09/2019) (NHS Business Service Authority - NHSBSA)	0.40	0.79	0.87	Significant Variation (positive)
The number of prescription items for co-amoxiclav, cephalosporins and quinolones as a percentage of the total number of prescription items for selected antibacterial drugs (BNF 5.1 sub-set). (01/10/2018 to 30/09/2019) (NHSBSA)	7.5%	8.1%	8.5%	No statistical variation
Average daily quantity per item for Nitrofurantoin 50 mg tablets and capsules, Nitrofurantoin 100 mg m/r capsules, Pivmecillinam 200 mg tablets and Trimethoprim 200 mg tablets prescribed for uncomplicated urinary tract infection (01/04/2019 to 30/09/2019) (NHSBSA)	4.60	4.82	5.60	No statistical variation
Average daily quantity of oral NSAIDs prescribed per Specific Therapeutic Group Age-sex Related Prescribing Unit (STAR-PU) (01/04/2019 to 30/09/2019) (NHSBSA)	1.31	2.18	2.08	No statistical variation

Medicines management	Y/N/Partial
The practice ensured medicines were stored safely and securely with access restricted to authorised staff.	Y
Blank prescriptions were kept securely, and their use monitored in line with national guidance.	Y
Staff had the appropriate authorisations to administer medicines (including Patient Group Directions or Patient Specific Directions).	Y
The practice could demonstrate the prescribing competence of non-medical prescribers, and there was regular review of their prescribing practice supported by clinical supervision or peer review.	N/A[1]
There was a process for the safe handling of requests for repeat medicines and evidence of structured medicines reviews for patients on repeat medicines.	Y
The practice had a process and clear audit trail for the management of information about changes to a patient's medicines including changes made by other services.	Y
There was a process for monitoring patients' health in relation to the use of medicines including high risk medicines (for example, warfarin, methotrexate and lithium) with appropriate monitoring and clinical review prior to prescribing.	Partial[2]
The practice monitored the prescribing of controlled drugs. (For example, investigation of unusual prescribing, quantities, dose, formulations and strength).	Y

Medicines management	Y/N/Partial
There were arrangements for raising concerns around controlled drugs with the NHS England Area Team Controlled Drugs Accountable Officer.	Y
If the practice had controlled drugs on the premises there were appropriate systems and written procedures for the safe ordering, receipt, storage, administration, balance checks and disposal of these medicines, which were in line with national guidance.	N/A[3]
The practice had taken steps to ensure appropriate antimicrobial use to optimise patient outcomes and reduce the risk of adverse events and antimicrobial resistance.	Y
For remote or online prescribing there were effective protocols for verifying patient identity.	Y
The practice held appropriate emergency medicines, risk assessments were in place to determine the range of medicines held, and a system was in place to monitor stock levels and expiry dates.	Partial[4]
There was medical oxygen and a defibrillator on site and systems to ensure these were regularly checked and fit for use.	Y
Vaccines were appropriately stored, monitored and transported in line with PHE guidance to ensure they remained safe and effective.	Y

Explanation of any answers and additional evidence:

Antibiotic prescribing at the practice was lower than local and national averages. The practice explained that they had achieved this by ensuring that they did not prescribe antibiotics until absolutely necessary. They also explained that they educated patients in good antimicrobial stewardship and had a good relationship with patients, which helped keep the numbers of requests for these medicines down.

1. The practice did not have any non-medical prescribers employed.
2. There were three patients on high risk medicines at the practice. We reviewed all patients on high risk medicines and found that one patient had not had up to date monitoring before being prescribed further medicines. This monitoring was ten weeks out of date.
3. The practice did not keep controlled drugs on the premises.
4. The practice was unable to demonstrate that they had all the recommended emergency medicines, or that they had considered the risk of not having these formally. During the inspection, the practice made the decision to stock all recommended emergency medicines and provided risk assessments for the interim period until they were delivered to the practice.

Track record on safety and lessons learned and improvements made

The practice learned and made improvements when things went wrong.

Significant events	Y/N/Partial
The practice monitored and reviewed safety using information from a variety of sources.	Y
Staff knew how to identify and report concerns, safety incidents and near misses.	Y
There was a system for recording and acting on significant events.	Y
Staff understood how to raise concerns and report incidents both internally and externally.	Y
There was evidence of learning and dissemination of information.	Y
Number of events recorded in last 12 months:	14

Number of events that required action:	14
Explanation of any answers and additional evidence:	

Example(s) of significant events recorded and actions by the practice.

Event	Specific action taken
Call system outage	In response to a failed system in relation to taking calls, the practice reviewed their policies and ensured that there was a system in place to check who had called the practice using a call dashboard and call these patients back as a priority.
Pharmacy error	In response to a significant event in relation to an error by the pharmacist, the practice system worked well to identify the error before medicines were issued to the patient in error. The practice reviewed their policies and ensured that they shared this with the pharmacy to reduce further errors going forward.

Safety alerts	Y/N/Partial
There was a system for recording and acting on safety alerts.	Y[1]
Staff understood how to deal with alerts.	Y
Explanation of any answers and additional evidence: 1. We reviewed three safety alerts and were assured that there was a comprehensive system in place to review relevant alerts and take action where necessary.	

Effective Rating: Inadequate

The practice was rated as inadequate for providing effective services because data for the practice in relation to cervical screening and childhood immunisations was lower than targets and the practice was unable to demonstrate any data that showed improvements or any actions to address this. In addition, the practice was also unable to demonstrate that the system in place to ensure quality improvement was effective or being used to make improvements.

Effective needs assessment, care and treatment

Patients' needs were assessed, and care and treatment were delivered in line with current legislation, standards and evidence-based guidance. This was supported by clear pathways and tools although there were some gaps.

	Y/N/Partial
The practice had systems and processes to keep clinicians up to date with current evidence-based practice.	Y
Patients' immediate and ongoing needs were fully assessed. This included their clinical needs and their mental and physical wellbeing.	Y
Patients presenting with symptoms which could indicate serious illness were followed up in a timely and appropriate way.	Y
We saw no evidence of discrimination when staff made care and treatment decisions.	Y
Patients' treatment was regularly reviewed and updated.	Partial[1]
There were appropriate referral pathways to make sure that patients' needs were addressed.	Y
Patients were told when they needed to seek further help and what to do if their condition deteriorated.	Y
The practice used digital services securely and effectively and conformed to relevant digital and information security standards.	Y
Explanation of any answers and additional evidence: 1. We found one patient out of three on high risk medicines had not had appropriate monitoring before the medicine was prescribed.	

Older people Population group rating: Good

Findings

- The practice used a clinical tool to identify older patients who were living with moderate or severe frailty. Those identified received a full assessment of their physical, mental and social needs.
- The practice followed up on older patients discharged from hospital. It ensured that their care plans and prescriptions were updated to reflect any extra or changed needs.
- The practice carried out structured annual medication reviews for older patients.
- Staff had appropriate knowledge of treating older people including their psychological, mental and communication needs.
- Health checks, including frailty assessments, were offered to patients over 75 years of age.

- Flu, shingles and pneumonia vaccinations were offered to relevant patients in this age group.

People with long-term conditions Population group rating: Good

Findings

- Patients with long-term conditions were offered a structured annual review to check their health and medicines needs were being met. For patients with the most complex needs, the GP worked with other health and care professionals to deliver a coordinated package of care.
- Staff who were responsible for reviews of patients with long-term conditions had received specific training.
- GPs followed up patients who had received treatment in hospital or through out of hours services for an acute exacerbation of asthma.
- The practice shared clear and accurate information with relevant professionals when deciding care delivery for patients with long-term conditions.
- The practice could demonstrate how they identified patients with commonly undiagnosed conditions, for example diabetes, chronic obstructive pulmonary disease (COPD), atrial fibrillation and hypertension.
- Adults with newly diagnosed cardio-vascular disease were offered statins.
- Patients with suspected hypertension were offered ambulatory blood pressure monitoring.
- Patients with atrial fibrillation were assessed for stroke risk and treated appropriately.
- Patients with asthma were offered an asthma management plan.

Diabetes Indicators	Practice	CCG average	England average	England comparison
The percentage of patients with diabetes, on the register, in whom the last IFCC-HbA1c is 64 mmol/mol or less in the preceding 12 months (01/04/2018 to 31/03/2019) (QOF)	74.8%	78.5%	79.3%	No statistical variation
Exception rate (number of exceptions).	5.2% (8)	7.8%	12.8%	N/A
The percentage of patients with diabetes, on the register, in whom the last blood pressure reading (measured in the preceding 12 months) is 140/80 mmHg or less (01/04/2018 to 31/03/2019) (QOF)	77.6%	75.1%	78.1%	No statistical variation
Exception rate (number of exceptions).	5.2% (8)	6.7%	9.4%	N/A

	Practice	CCG average	England average	England comparison
The percentage of patients with diabetes, on the register, whose last measured total cholesterol (measured within the preceding 12 months) is 5 mmol/l or less (01/04/2018 to 31/03/2019) (QOF)	91.7%	83.1%	81.3%	Variation (positive)
Exception rate (number of exceptions).	6.5% (10)	6.7%	12.7%	N/A

Other long-term conditions	Practice	CCG average	England average	England comparison
The percentage of patients with asthma, on the register, who have had an asthma review in the preceding 12 months that includes an assessment of asthma control using the 3 RCP questions, NICE 2011 menu ID: NM23 (01/04/2018 to 31/03/2019) (QOF)	94.4%	77.7%	75.9%	Significant Variation (positive)
Exception rate (number of exceptions).	3.6% (4)	4.9%	7.4%	N/A
The percentage of patients with COPD who have had a review, undertaken by a healthcare professional, including an assessment of breathlessness using the Medical Research Council dyspnoea scale in the preceding 12 months (01/04/2018 to 31/03/2019) (QOF)	100.0%	90.4%	89.6%	Variation (positive)
Exception rate (number of exceptions).	11.1% (2)	10.1%	11.2%	N/A

Indicator	Practice	CCG average	England average	England comparison
The percentage of patients with hypertension in whom the last blood pressure reading measured in the preceding 12 months is 150/90mmHg or less (01/04/2018 to 31/03/2019) (QOF)	82.4%	82.4%	83.0%	No statistical variation
Exception rate (number of exceptions).	5.9% (12)	3.7%	4.0%	N/A
In those patients with atrial fibrillation with a record of a CHA2DS2-VASc score of 2 or more, the percentage of patients who are currently treated with anti-coagulation drug therapy (01/04/2018 to 31/03/2019) (QOF)	81.8%	92.8%	91.1%	No statistical variation
Exception rate (number of exceptions).	8.3% (1)	4.8%	5.9%	N/A

Any additional evidence or comments
The practice had a comprehensive system to reviewing their patients who had long-term conditions,

including patients with Diabetes, Asthma and Chronic Obstructive Pulmonary Disease (COPD). Due to the practice population, they also had small numbers of these patients, which they told us were patients they knew well and managed their conditions well.

Families, children and young people Population group rating: Inadequate

Findings

- The practice had not met the minimum 90% target for all four childhood immunisation uptake indicators. The practice had also not met the WHO based national target of 95% (the recommended standard for achieving herd immunity) for any of the four childhood immunisation uptake indicators. The practice was aware of their low uptake and explained that their nurse had left recently, which had had a negative impact upon their ability to immunise children. They also explained that they had challenges with their population refusing to allow their children to be immunised. The practice was unable to provide any updated data to demonstrate that improvements had taken place. They were further unable to demonstrate any proactive actions taken to address the low uptake.
- The practice contacted the parents or guardians of children due to have childhood immunisations.
- The practice was unable to demonstrate arrangements for following up failed attendance of children's appointments following an appointment in secondary care or for immunisation and would liaise with health visitors when necessary.
- The practice had arrangements to identify and review the treatment of newly pregnant women on long-term medicines. These patients were provided with advice and post-natal support in accordance with best practice guidance.
- Young people could access services for sexual health and contraception.
- Staff had the appropriate skills and training to carry out reviews for this population group.

Child Immunisation	Numerator	Denominator	Practice %	Comparison to WHO target of 95%
The percentage of children aged 1 who have completed a primary course of immunisation for Diphtheria, Tetanus, Polio, Pertussis, Haemophilus influenza type b (Hib), Hepatitis B (Hep B) ((i.e. three doses of DTaP/IPV/Hib/HepB) (01/04/2018 to 31/03/2019) (NHS England)	40	46	87.0%	Below 90% minimum
The percentage of children aged 2 who have received their booster immunisation for Pneumococcal infection (i.e. received Pneumococcal booster) (PCV booster) (01/04/2018 to 31/03/2019) (NHS England)	34	49	69.4%	Below 80% uptake
The percentage of children aged 2 who have received their immunisation for Haemophilus influenza type b (Hib) and Meningitis C (MenC) (i.e. received	34	49	69.4%	Below 80% uptake

Hib/MenC booster) (01/04/2018 to 31/03/2019) (NHS England)				
The percentage of children aged 2 who have received immunisation for measles, mumps and rubella (one dose of MMR) (01/04/2018 to 31/03/2019) (NHS England)	33	49	67.3%	Below 80% uptake

Note: Please refer to the CQC guidance on Childhood Immunisation data for more information: https://www.cqc.org.uk/guidance-providers/gps/how-we-monitor-gp-practices

Any additional evidence or comments

Working age people (including those recently retired and students)

Population group rating: Inadequate

Findings

- The practice had not met the 80% target uptake for cervical screening. They were aware of their lower than average uptake and explained that this was partly due to their population and partly due to them losing both their nurse and HCA recently. The practice was unable to provide any verified data to demonstrate that improvements had taken place. They were further unable to demonstrate any proactive actions taken to address the low uptake.
- The practice had systems to inform eligible patients to have the meningitis vaccine, for example before attending university for the first time.
- Patients had access to appropriate health assessments and checks including NHS checks for patients aged 40 to 74. There was appropriate and timely follow-up on the outcome of health assessments and checks where abnormalities or risk factors were identified.
- Patients could book or cancel appointments online and order repeat medication without the need to attend the surgery.

Cancer Indicators	Practice	CCG average	England average	England comparison
The percentage of women eligible for cervical cancer screening at a given point in time who were screened adequately within a specified period (within 3.5 years for women aged 25 to 49, and within 5.5 years for women aged 50 to 64). (31/03/2019 to 30/06/2019) (Public Health England)	56.2%	N/A	80% Target	Below 70% uptake
Females, 50-70, screened for breast cancer in last 36 months (3-year coverage, %) (01/04/2018 to 31/03/2019) (PHE)	59.7%	63.5%	71.6%	N/A
Persons, 60-69, screened for bowel cancer in last 30 months (2.5-year coverage, %) (01/04/2018 to 31/03/2019) (PHE)	48.1%	43.8%	58.0%	N/A
The percentage of patients with cancer, diagnosed within the preceding 15 months, who have a patient review recorded as	16.7%	59.1%	68.1%	N/A

occurring within 6 months of the date of diagnosis. (01/04/2018 to 31/03/2019) (PHE)				
Number of new cancer cases treated (Detection rate: % of which resulted from a two week wait (TWW) referral) (01/04/2018 to 31/03/2019) (PHE)	25.0%	50.1%	53.8%	No statistical variation

Any additional evidence or comments

Unverified data provided by the practice showed that the percentage of eligible patients screened between the ages 25-49 was 60% and that number rose to 82.7% for those patients aged 50-64. This data was not fully comparable with data used by Public Health England.

The practice explained that the lower than average percentage of patients reviewed within six months of diagnosis of cancer, was due to low numbers of patients involved and an identified coding error, which has skewed the data. The practice also told us that staff needed training updated to perform this function, but the GPs would be taking a more active role in this. Although the practice recognised that there was further work to do, we were assured that those patients, whose records we viewed, who had been diagnosed with cancer, had been appropriately reviewed.

The practice told us that there was a national issue with waiting times for cancer diagnosis, this was coupled with a coding issue and small numbers of patients involved have skewed the data.

People whose circumstances make them vulnerable

Population group rating: Good

Findings

- Same day appointments and longer appointments were offered when required.
- All patients with a learning disability were offered an annual health check.
- End of life care was delivered in a coordinated way which took into account the needs of those whose circumstances may make them vulnerable.
- The practice had a system for vaccinating patients with an underlying medical condition according to the recommended schedule.
- The practice demonstrated that they had a system to identify people who misused substances.

People experiencing poor mental health (including people with dementia)

Population group rating: Good

Findings

- The practice assessed and monitored the physical health of people with mental illness and personality disorder by providing access to health checks, interventions for physical activity, obesity, diabetes, heart disease, cancer and access to ‘stop smoking’ services.
- Same day and longer appointments were offered when required.
- There was a system for following up patients who failed to attend for administration of long-term medication.

- When patients were assessed to be at risk of suicide or self-harm the practice had arrangements in place to help them to remain safe.
- Patients at risk of dementia were identified and offered an assessment to detect possible signs of dementia. When dementia was suspected there was an appropriate referral for diagnosis.
- All staff had received dementia training, but this was just outside the last 12 months.
- Patients with poor mental health, including dementia, were referred to appropriate services.

Mental Health Indicators	Practice	CCG average	England average	England comparison
The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a comprehensive, agreed care plan documented in the record, in the preceding 12 months (01/04/2018 to 31/03/2019) (QOF)	91.7%	87.0%	89.4%	No statistical variation
Exception rate (number of exceptions).	7.7% (2)	11.8%	12.3%	N/A
The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses whose alcohol consumption has been recorded in the preceding 12 months (01/04/2018 to 31/03/2019) (QOF)	92.0%	88.8%	90.2%	No statistical variation
Exception rate (number of exceptions).	3.8% (1)	9.5%	10.1%	N/A
The percentage of patients diagnosed with dementia whose care plan has been reviewed in a face-to-face review in the preceding 12 months (01/04/2018 to 31/03/2019) (QOF)	100.0%	82.6%	83.6%	Tending towards variation (positive)
Exception rate (number of exceptions).	20.0% (1)	6.5%	6.7%	N/A

Any additional evidence or comments
The practice had very low numbers of patients with dementia, due to their population profile. This also accounted for the high exception reporting for those patients. One patient accounting for 20% of the practice population with dementia. Records we viewed confirmed this.

Monitoring care and treatment

There was limited monitoring of the outcomes of care and treatment.

Indicator	Practice	CCG average	England average
Overall QOF score (out of maximum 559)	520.2	530.8	539.2
Overall QOF score (as a percentage of maximum)	94.6%	95.2%	96.7%
Overall QOF exception reporting (all domains)	8.3%	5.9%	5.9%

	Y/N/Partial
Clinicians took part in national and local quality improvement initiatives.	Y
The practice had a programme of quality improvement and used information about care and treatment to make improvements.	Y[1]
Quality improvement activity was targeted at the areas where there were concerns.	N[2]
The practice regularly reviewed unplanned admissions and readmissions and took appropriate action.	Y

1. Following the inspection, the practice provided us with evidence of one double cycle clinical audit, conducted by the CCG pharmacist, that indicated positive outcomes for patients. This was in regard to antibiotics.

2. The practice had a system for quality assurance activity. We saw that this was not always aligned with concerns for the practice, rather those that had been guided by the Clinical Commissioning Group (CCG). The practice demonstrated that they had completed audits on joint injections; this was a single cycle audit but was rated at 100%. The practice also told us that they had CCG pharmacist audits in relation to prescribing, but due to the loss of the previous practice manager, were unable to provide these for us.

   In addition, an audit about patients HbA1c (Diabetes blood levels) showed that in July 2018, out of 53 patients that were out of range (whose HbA1c was higher or lower than they should be), 20 patients following the audit had not been tested. This was marked on the audit as a priority area. The practice told us that they had re-audited this in March 2019 and were confident that all these patients had been tested and were being well-managed, they were unable to produce the second audit, or provide any assurances that these patients had all been tested. The system for quality assurance was not effective as the practice did not have access to the data needed to learn from or to drive improvements for patients.
   Following the inspection, the practice informed us that they had communicated with the CCG pharmacist who had conducted the audit cycle. The Pharmacist had recalled that the result of the re-audit indicated that four patients out of the original 20 remained untested for their HbA1c. The practice was unable to access the details of these patients until the Pharmacist had revisited as no data was removed from the practice and the leadership were unable to access the data. They told us that a likely explanation for these four patients was that they had been invited multiple times for this test and had not attended. The practice told us that all patients were invited through their recall system, according to the patient's birth date and this system was effective. Records we viewed indicated that the practice "call and recall" system was effective.

Effective staffing

Staff at the practice were able to demonstrate that they had the skills, knowledge and experience to carry out their roles, however, the practice was unable to demonstrate a cohesive system was yet in place or embedded to ensure or oversee this.

	Y/N/Partial
Staff had the skills, knowledge and experience to deliver effective care, support and treatment. This included specific training for nurses on immunisation and on sample taking for the cervical screening programme.	Y

The learning and development needs of staff were assessed.	N[1]
The practice had a programme of learning and development.	N[1]
Staff had protected time for learning and development.	Y
There was an induction programme for new staff.	Y
Induction included completion of the Care Certificate for Health Care Assistants employed since April 2015.	N/A[2]
Staff had access to regular appraisals, one to ones, coaching and mentoring, clinical supervision and revalidation. They were supported to meet the requirements of professional revalidation.	Partial[3]
The practice could demonstrate how they assured the competence of staff employed in advanced clinical practice, for example, nurses, paramedics, pharmacists and physician associates.	Y
There was a clear and appropriate approach for supporting and managing staff when their performance was poor or variable.	Y

Explanation of any answers and additional evidence:

1. The practice management had only been in place since December 2019 and did not have access to training software that the practice used to manage staff training. Although the practice admitted that this was an area they needed to work on and we saw that staff training had expired by two days, there was no system in place to assess or deliver the training needs of the staff.
2. The practice did not have a Health Care Assistant (HCA) employed.
3. The staff we spoke with told us that they had had appraisals completed last year, but the practice was unable to demonstrate this and could only provide appraisals from 2016. There was no system in place to ensure that governance systems could continue following the departure of a single member of the management team.

Coordinating care and treatment

The practice could not fully demonstrate that staff worked together and with other organisations to deliver effective care and treatment.

Indicator	Y/N/Partial
The contractor has regular (at least 3 monthly) multidisciplinary case review meetings where all patients on the palliative care register are discussed (01/04/2018 to 31/03/2019) (QOF)	Partial[1]
We saw records that showed that all appropriate staff, including those in different teams and organisations, were involved in assessing, planning and delivering care and treatment.	N[1]
Care was delivered and reviewed in a coordinated way when different teams, services or organisations were involved.	Partial[1]
Patients received consistent, coordinated, person-centred care when they moved between services.	Y
For patients who accessed the practice's digital service there were clear and effective processes to make referrals to other services.	Y

Explanation of any answers and additional evidence:

1. The practice could not demonstrate that Multi-Disciplinary Team (MDT) meetings had taken place. The practice told us that other professionals were invited to meetings, but these meetings were not documented, and no evidence of invites could be provided. The practice was further unable to demonstrate that clinical meetings took place. They told us that they had daily huddles, but no evidence could be provided, when asked, of discussions that had taken place concerning patients who were complex or at risk.

Helping patients to live healthier lives

Staff were consistent and proactive in helping patients to live healthier lives.

	Y/N/Partial
The practice identified patients who may need extra support and directed them to relevant services. This included patients in the last 12 months of their lives, patients at risk of developing a long-term condition and carers.	Y
Staff encouraged and supported patients to be involved in monitoring and managing their own health.	Y
Patients had access to appropriate health assessments and checks.	Y
Staff discussed changes to care or treatment with patients and their carers as necessary.	Y
The practice supported national priorities and initiatives to improve the population's health, for example, stop smoking campaigns, tackling obesity.	Y
Explanation of any answers and additional evidence:	

Smoking Indicator	Practice	CCG average	England average	England comparison
The percentage of patients with any or any combination of the following conditions: CHD, PAD, stroke or TIA, hypertension, diabetes, COPD, CKD, asthma, schizophrenia, bipolar affective disorder or other psychoses whose notes record smoking status in the preceding 12 months (01/04/2018 to 31/03/2019) (QOF)	100.0%	96.5%	95.0%	Significant Variation (positive)
Exception rate (number of exceptions).	0.5% (2)	1.0%	0.8%	N/A

Any additional evidence or comments
The practice explained that they had low numbers of patients in the above categories, due to their patient profile but that those who were, managed their condition well and were compliant with review requests made by the practice.

Consent to care and treatment

The practice always obtained consent to care and treatment in line with legislation

and guidance.

	Y/N/Partial
Clinicians understood the requirements of legislation and guidance when considering consent and decision making. We saw that consent was documented.	Y
Clinicians supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision.	Y
The practice monitored the process for seeking consent appropriately.	Y
Policies for any online services offered were in line with national guidance.	Y
Explanation of any answers and additional evidence:	

Caring Rating: Good

Kindness, respect and compassion

Staff treated patients with kindness, respect and compassion. Feedback from patients was generally positive about the way staff treated people.

	Y/N/Partial
Staff understood and respected the personal, cultural, social and religious needs of patients.	Y
Staff displayed understanding and a non-judgemental attitude towards patients.	Y
Patients were given appropriate and timely information to cope emotionally with their care, treatment or condition.	Y
Explanation of any answers and additional evidence:	
CQC comments cards	
Total comments cards received.	21
Number of CQC comments received which were positive about the service.	17
Number of comments cards received which were mixed about the service.	3
Number of CQC comments received which were negative about the service.	1

Source	Feedback
CQC comment cards	Of the 21 comment cards we received, nine were specific about kindness, respect and compassion shown by staff and were positive.
NHS Choices Website	Of the 11 reviews left on the NHS Choices website in the last 12 months, six were specific about kindness, respect and compassion shown by staff; four were positive and two were less positive.

National GP Survey results

Practice population size	Surveys sent out	Surveys returned	Survey Response rate%	% of practice population
3044.0	448.0	76.0	17.0%	2.50%

Indicator	Practice	CCG average	England average	England comparison
The percentage of respondents to the GP patient survey who stated that the last time they had a general practice appointment, the healthcare professional was good or very good at listening to them (01/01/2019 to 31/03/2019)	83.0%	84.7%	88.9%	No statistical variation

Indicator	Practice	CCG average	England average	England comparison
The percentage of respondents to the GP patient survey who stated that the last time they had a general practice appointment, the healthcare professional was good or very good at treating them with care and concern (01/01/2019 to 31/03/2019)	82.9%	82.0%	87.4%	No statistical variation
The percentage of respondents to the GP patient survey who stated that during their last GP appointment they had confidence and trust in the healthcare professional they saw or spoke to (01/01/2019 to 31/03/2019)	89.8%	91.7%	95.5%	No statistical variation
The percentage of respondents to the GP patient survey who responded positively to the overall experience of their GP practice (01/01/2019 to 31/03/2019)	67.6%	74.9%	82.9%	No statistical variation

Question	Y/N
The practice carries out its own patient survey/patient feedback exercises.	Y

Any additional evidence
Although the practice did not conduct internal surveys, they did provide opportunities for patients to feedback, through complaints, feedback forms in the reception area and they did respond to comments on the NHS Choices website.

Involvement in decisions about care and treatment

Staff helped patients to be involved in decisions about care and treatment.

	Y/N/Partial
Staff communicated with patients in a way that helped them to understand their care, treatment and condition, and any advice given.	Y
Staff helped patients and their carers find further information and access community and advocacy services.	Y
Explanation of any answers and additional evidence: The practice staff we spoke with knew how to access materials in other languages and in easy read formats, they were also familiar with the process for obtaining an interpreter for patients, although there were some difficulties reported with the local system for this.	

Source	Feedback
Interviews with patients.	Patients we spoke with were positive about the practice generally and about the practice staff. They stated that staff treated patients with kindness, respect and maintained their dignity within a caring environment.

National GP Survey results

Indicator	Practice	CCG average	England average	England comparison
The percentage of respondents to the GP patient survey who stated that during their last GP appointment they were involved as much as they wanted to be in decisions about their care and treatment (01/01/2019 to 31/03/2019)	86.0%	90.5%	93.4%	No statistical variation

	Y/N/Partial
Interpretation services were available for patients who did not have English as a first language.	Y
Patient information leaflets and notices were available in the patient waiting area which told patients how to access support groups and organisations.	Y
Information leaflets were available in other languages and in easy read format.	Y
Information about support groups was available on the practice website.	N[1]
Explanation of any answers and additional evidence: 1. The practice told us that their website was about to be updated to another format where information about support organisations would be added.	

Carers	Narrative
Percentage and number of carers identified.	The practice had a register of 64 carers, which is approximately 2% of the practice population.
How the practice supported carers (including young carers).	The practice provided flu vaccinations and health checks for carers. They also provided signposting to support organisations for these patients.
How the practice supported recently bereaved patients.	The practice provided out of hours death certificates for patients in a culturally sensitive manner. They also offered condolences to deceased patients' families and appointments for referral to counselling services if necessary.

Privacy and dignity

The practice respected patients' privacy and dignity.

	Y/N/Partial
Curtains were provided in consulting rooms to maintain patients' privacy and dignity during examinations, investigations and treatments.	Y
Consultation and treatment room doors were closed during consultations.	Y
A private room was available if patients were distressed or wanted to discuss sensitive issues.	Y
There were arrangements to ensure confidentiality at the reception desk.	Y
Explanation of any answers and additional evidence:	

Responsive Rating: Good

Responding to and meeting people's needs

The practice organised and delivered services to meet patients' needs.

	Y/N/Partial
The practice understood the needs of its local population and had developed services in response to those needs.	Y
The importance of flexibility, informed choice and continuity of care was reflected in the services provided.	Y
The facilities and premises were appropriate for the services being delivered.	Y
The practice made reasonable adjustments when patients found it hard to access services.	Y
There were arrangements in place for people who need translation services.	Y
The practice complied with the Accessible Information Standard.	Y
Explanation of any answers and additional evidence:	

Practice Opening Times	
Day	**Time**
Opening times:	
Monday	8am – 6.30pm
Tuesday	8am – 6.30pm
Wednesday	8am – 6.30pm
Thursday	8am – 6.30pm
Friday	8am – 6.30pm
Appointments available:	
Monday	8am – 6.20pm
Tuesday	8am – 6.20pm
Wednesday	8am – 6.20pm
Thursday	8am – 6.20pm
Friday	8am – 6.20pm
Additional access	The practice offers patients additional access to appointments at local hub centres provided by the Clinical Commissioning Group (CCG).

National GP Survey results

Practice population size	Surveys sent out	Surveys returned	Survey Response rate%	% of practice population
3044.0	448.0	76.0	17.0%	2.50%

Indicator	Practice	CCG average	England average	England comparison
The percentage of respondents to the GP patient survey who stated that at their last general practice appointment, their needs were met (01/01/2019 to 31/03/2019)	87.8%	91.6%	94.5%	No statistical variation

Any additional evidence or comments

Older people — Population group rating: Good

Findings

- All patients had a named GP who supported them in whatever setting they lived.
- The practice was responsive to the needs of older patients and offered home visits and urgent appointments for those with enhanced needs and complex medical issues.
- The practice provided effective care coordination to enable older patients to access appropriate services.
- In recognition of the religious and cultural observances of some patients, the GP would respond quickly, often outside of normal working hours, to provide the necessary death certification to enable prompt burial in line with families' wishes when bereavement occurred.

People with long-term conditions — Population group rating: Good

Findings

- Patients with multiple conditions had their needs reviewed in one appointment.
- The practice provided effective care coordination to enable patients with long-term conditions to access appropriate services.
- The practice liaised regularly with the local district nursing team and community matrons to discuss and manage the needs of patients with complex medical issues.
- Care and treatment for people with long-term conditions approaching the end of life was coordinated with other services.

Families, children and young people — Population group rating: Good

Findings

- Nurse appointments were no longer available at the practice and nursing services were referred out to other providers until the practice could replace its nursing staff, including the Health Care Assistant (HCA).
- We found there were systems to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of accident and emergency (A&E) attendances. Records we looked at confirmed this.
- All parents or guardians calling with concerns about a child were offered a same day appointment when necessary.

Working age people (including those recently retired and students)

Population group rating: Good

Findings

- The needs of this population group had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care.
- The practice was open until 6.30pm on a Monday to Friday. Pre-bookable appointments were also available to all patients at additional locations within the area, due to services provided by the CCG. Appointments at these hubs were available on weekdays from 8am until 8pm and at weekends.

People whose circumstances make them vulnerable

Population group rating: Good

Findings

- The practice held a register of patients living in vulnerable circumstances including those with a learning disability. Staff we spoke to were not fully aware of how they would register patients who were homeless.
- We saw that some people in vulnerable circumstances had been able to register with the practice, including those with no fixed abode such as Travellers.
- The practice provided effective care coordination to enable patients living in vulnerable circumstances to access appropriate services.
- The practice adjusted the delivery of its services to meet the needs of patients with a learning disability.

People experiencing poor mental health (including people with dementia)

Population group rating: Good

Findings

- Priority appointments were allocated when necessary to those experiencing poor mental health.
- Staff we spoke with had a good understanding of how to support patients with mental health needs and those patients living with dementia.
- The practice was aware of support groups within the area and signposted their patients to these accordingly.

Timely access to the service

People were able to access care and treatment in a timely way.

National GP Survey results

	Y/N/Partial
Patients with urgent needs had their care prioritised.	Y
The practice had a system to assess whether a home visit was clinically necessary and the urgency of the need for medical attention.	Y
Appointments, care and treatment were only cancelled or delayed when absolutely necessary.	Y
Explanation of any answers and additional evidence:	

Indicator	Practice	CCG average	England average	England comparison
The percentage of respondents to the GP patient survey who responded positively to how easy it was to get through to someone at their GP practice on the phone (01/01/2019 to 31/03/2019)	78.0%	N/A	68.3%	No statistical variation
The percentage of respondents to the GP patient survey who responded positively to the overall experience of making an appointment (01/01/2019 to 31/03/2019)	59.9%	58.5%	67.4%	No statistical variation
The percentage of respondents to the GP patient survey who were very satisfied or fairly satisfied with their GP practice appointment times (01/01/2019 to 31/03/2019)	60.1%	60.4%	64.7%	No statistical variation
The percentage of respondents to the GP patient survey who were satisfied with the type of appointment (or appointments) they were offered (01/01/2019 to 31/03/2019)	55.4%	65.7%	73.6%	No statistical variation

Source	Feedback
NHS Choices Website	Out of the 11 reviews on the NHS choices website, nine were specific about access to care and treatment; Four were positive and five were less positive.
CQC comment cards	Of the 21 comment cards we received, six were specific about access to care and treatment. Four were positive and two were less than positive.

Listening and learning from concerns and complaints

Complaints were listened and responded to and used to improve the quality of care.

Complaints	
Number of complaints received in the last year.	10
Number of complaints we examined.	6

Number of complaints we examined that were satisfactorily handled in a timely way.	6
Number of complaints referred to the Parliamentary and Health Service Ombudsman.	0

	Y/N/Partial
Information about how to complain was readily available.	Y
There was evidence that complaints were used to drive continuous improvement.	Y
Explanation of any answers and additional evidence: The practice had a system for ensuring that both verbal and written complaints were reviewed, and action taken as a result. We saw comprehensive learning points and that these were discussed in the newly implemented team meetings.	

Example(s) of learning from complaints.

Complaint	Specific action taken
Information given to patients before treatment	In response to a complaint concerning patient misunderstanding of the treatment they accessed, the practice reviewed their policies and procedures to ensure that staff redouble their efforts to provide detailed and understandable information to patients before treatment is given and to ensure patients understand and are involved in the treatment decision.
Prescription consent	Following a complaint in relation to a prescription collection consent confusion, the practice ensured that all patients were asked about consent for others to pick up their prescriptions. This information was then entered onto the clinical system rather than a physical piece of paper, which could be lost or misplaced. The practice told us that this system appeared to be working a lot better.

Well-led Rating: Requires Improvement

The practice was rated as requires improvement for providing well-led services because, prior to the new management, the practice was unable to demonstrate that systems to keep patient fully safe or to oversee systems and process in relation to overall governance, were effective or working as intended, which led to gaps. During the inspection, the practice was unable to demonstrate that all of these had yet been resolved, but the practice was aware of the majority of these and assured us that action would be taken to address these as soon as practicable. Systems put in place since December 2019, were not yet fully embedded but we were confident that these were established within a framework that now focused on addressing the shortfalls that were identified and mitigating future risk of these reoccurring.

Leadership capacity and capability

There was compassionate, inclusive leadership at all levels, however, the practice could not always demonstrate that systems to support the leadership team were yet fully effective.

	Y/N/Partial
Leaders demonstrated that they understood the challenges to quality and sustainability.	Y
They had identified the actions necessary to address these challenges.	Y[1]
Staff reported that leaders were visible and approachable.	Y
There was a leadership development programme, including a succession plan.	N[2]

Explanation of any answers and additional evidence:

1. The provider was aware of the majority of the concerns that we identified during the inspection. New leadership at the practice had implemented systems proactively, that were not yet fully embedded, but were designed to address the issues that we had identified. We saw that there were areas that had not yet been resolved however due to the practice response the risk had been somewhat mitigated.
2. The practice did not have a formal succession plan in place, although long term locums at the practice would be able to continue the service in the event that the lead GP could no longer.

Vision and strategy

The practice had a clear vision and had established a credible strategy to provide high quality sustainable care.

	Y/N/Partial
The practice had a clear vision and set of values that prioritised quality and sustainability.	Y
There was a realistic strategy to achieve their priorities.	Y
The vision, values and strategy were developed in collaboration with staff, patients and external partners.	Y
Staff knew and understood the vision, values and strategy and their role in achieving them.	Y

Progress against delivery of the strategy was monitored.	Y
Explanation of any answers and additional evidence: The practice demonstrated that informal action plans had been created to address the majority of the issues, those that they were aware of. Although many of the concerns had not yet been fully addressed and some had not yet been considered, there was a focus and a commitment from the leadership team to do things differently and ensure that they were open and transparent about their process.	

Culture

The practice had a culture which drove high quality sustainable care.

	Y/N/Partial
There were arrangements to deal with any behaviour inconsistent with the vision and values.	Y
Staff reported that they felt able to raise concerns without fear of retribution.	Y
There was a strong emphasis on the safety and well-being of staff.	Y
There were systems to ensure compliance with the requirements of the duty of candour.	Y
When people were affected by things that went wrong they were given an apology and informed of any resulting action.	Y
The practice encouraged candour, openness and honesty.	Y
The practice's speaking up policies were in line with the NHS Improvement Raising Concerns (Whistleblowing) Policy.	Y
The practice had access to a Freedom to Speak Up Guardian.	Y
Staff had undertaken equality and diversity training.	Partial[1]
Explanation of any answers and additional evidence: 1. Staff had completed training around equality and diversity however it was due for review. Practice leadership told us that they did not yet have access to the software used to track and manage staff training, but that this would be a priority going forward given that a number of areas of training had lapsed.	

Examples of feedback from staff or other evidence about working at the practice

Source	Feedback
Staff conversations	Staff we spoke with were happy working at the practice. They felt that the new leadership was approachable and managed in a style consistent with how they worked best. They were proud of the work they did.

Governance arrangements

There were clear, newly established responsibilities, roles and systems of accountability to support good governance and management.

	Y/N/Partial
There were governance structures and systems which were regularly reviewed.	Y

Staff were clear about their roles and responsibilities.	Y
There were appropriate governance arrangements with third parties.	Y
Explanation of any answers and additional evidence: The practice demonstrated that newly established systems were designed to address the concerns with the governance systems, specifically around risk and more generally in terms of oversight, which had been lacking, leading to gaps. Prior to December 2019, these systems had not been in place or effective and systems were in the process of being embedded.	

Managing risks, issues and performance

The practice did not yet have clear and effective processes for managing risks, issues and performance.

	Y/N/Partial
There were comprehensive assurance systems which were regularly reviewed and improved.	N[1]
There were processes to manage performance.	Y
There was a systematic programme of clinical and internal audit.	Partial[2]
There were effective arrangements for identifying, managing and mitigating risks.	N[3]
A major incident plan was in place.	Y
Staff were trained in preparation for major incidents.	Y
When considering service developments or changes, the impact on quality and sustainability was assessed.	Y

Explanation of any answers and additional evidence:

1. The practice was unable to demonstrate that there were yet effective systems in place to manage and mitigate risks to patients. The practice was generally aware of the overall risk areas but were unable to demonstrate that they were aware of the areas of clinical risk we identified. They lacked oversight but assured us that they would take immediate action to address these.
2. The practice, whilst demonstrating some quality improvement activity in the form of audits, did not have an effective system in place, that focused on risk or any elements outside of those guided by the CCG. They were also unable to demonstrate that there was oversight of the results of this quality improvement activity to drive improvement.
3. The practice was not able to demonstrate a comprehensive or fully consistent approach to managing risks.

Appropriate and accurate information

The practice could not demonstrate that they always acted on appropriate and accurate information.

	Y/N/Partial
Staff used data to adjust and improve performance.	Partial[1]
Performance information was used to hold staff and management to account.	Y

Our inspection indicated that information was accurate, valid, reliable and timely.	Partial[2]
Staff whose responsibilities included making statutory notifications understood what this entails.	N[3]
Explanation of any answers and additional evidence: 1. Although the practice used information in relation to Quality Outcome Framework (Qof) data to make adjustments to their service delivery to drive improvement, there were areas, where the practice was unable to demonstrate that they had taken action to address. For example, cervical screening and childhood immunisations. 2. We identified one area where coding errors had impacted on the data, in relation to cancer patients. This was a small number of patients and the practice committed to addressing this immediately. 3. The recently established leadership team acknowledged that there were areas that they were unfamiliar with, notifications to the Care Quality Commission (CQC) was one such area and the practice assured us that this would make up part of their future training and development.	

Engagement with patients, the public, staff and external partners

The practice involved the public, staff and external partners to sustain high quality and sustainable care.

	Y/N/Partial
Patient views were acted on to improve services and culture.	Y
The practice had an active Patient Participation Group.	N[1]
Staff views were reflected in the planning and delivery of services.	Y
The practice worked with stakeholders to build a shared view of challenges and of the needs of the population.	Y
Explanation of any answers and additional evidence: 1. The patient participation group had not met for at least 12 months, but the practice told us that they had plans to energise the PPG with digital forums to encourage as many people to contribute as possible.	

Feedback from Patient Participation Group.

Feedback
Members of the PPG that we spoke with, were positive about the practice and staff in relation to their attitude, their service delivery, access to care and treatment and the newly established leadership.

Continuous improvement and innovation

There was limited evidence of systems and processes for learning, continuous improvement and innovation.

	Y/N/Partial
There was a strong focus on continuous learning and improvement.	Partial[1]
Learning was shared effectively and used to make improvements.	Y
Explanation of any answers and additional evidence:	

1. The practice had a comprehensive, newly established system for considering and learning from complaints, received both verbally and in written format. Other quality improvement activity was limited however, particularly in relation to clinical audits.

Notes: CQC GP Insight

GP Insight assesses a practice's data against all the other practices in England. We assess relative performance for the majority of indicators using a "z-score" (this tells us the number of standard deviations from the mean the data point is), giving us a statistical measurement of a practice's performance in relation to the England average. We highlight practices which significantly vary from the England average (in either a positive or negative direction). We consider that z-scores which are higher than +2 or lower than -2 are at significant levels, warranting further enquiry. Using this technique we can be 95% confident that the practices performance is genuinely different from the average. It is important to note that a number of factors can affect the Z score for a practice, for example a small denominator or the distribution of the data. This means that there will be cases where a practice's data looks quite different to the average, but still shows as no statistical variation, as we do not have enough confidence that the difference is genuine. There may also be cases where a practice's data looks similar across two indicators, but they are in different variation bands.

The percentage of practices which show variation depends on the distribution of the data for each indicator, but is typically around 10-15% of practices. The practices which are not showing significant statistical variation are labelled as no statistical variation to other practices.

N.B. Not all indicators in the evidence table are part of the GP insight set and those that aren't will not have a variation band.

The following language is used for showing variation:

Variation Bands	Z-score threshold
Significant variation (positive)	≤-3
Variation (positive)	>-3 and ≤-2
Tending towards variation (positive)	>-2 and ≤-1.5
No statistical variation	<1.5 and >-1.5
Tending towards variation (negative)	≥1.5 and <2
Variation (negative)	≥2 and <3
Significant variation (negative)	≥3

Note: for the following indicators the variation bands are different:

- Child Immunisation indicators. These are scored against the World Health Organisation target of 95% rather than the England average. Note that practices that have "Met 90% minimum" have not met the WHO target of 95%.
- The percentage of respondents to the GP patient survey who responded positively to how easy it was to get through to someone at their GP practice on the phone uses a rules based approach for scoring, due to the distribution of the data. This indicator does not have a CCG average.
- The percentage of women eligible for cervical cancer screening at a given point in time who were screened adequately within a specified period (within 3.5 years for women aged 25 to 49, and within 5.5 years for women aged 50 to 64). This indicator does not have a CCG average and is scored against the national target of 80%.

It is important to note that z-scores are not a judgement in themselves, but will prompt further enquiry, as part of our ongoing monitoring of GP practices.

Guidance and Frequently Asked Questions on GP Insight can be found on the following link:
https://www.cqc.org.uk/guidance-providers/gps/how-we-monitor-gp-practices

Note: The CQC GP Evidence Table uses the most recent validated and publicly available data. In some cases at the time of inspection this data may be relatively old. If during the inspection the practice has provided any more recent data, this can be considered by the inspector. However, it should be noted that any data provided by the practice will be unvalidated and is not directly comparable to the published data. This has been taken into account during the inspection process.

Glossary of terms used in the data.

- **COPD**: Chronic Obstructive Pulmonary Disease
- **PHE**: Public Health England
- **QOF**: Quality and Outcomes Framework
- **STAR-PU**: Specific Therapeutic Group Age-sex weightings Related Prescribing Units. These weighting allow more accurate and meaningful comparisons within a specific therapeutic group by taking into account the types of people who will be receiving that treatment.